Estates and Facilities Alert

Action

Ref: EFA/2010/003 **Issued:** 29 March at 14:30

Device

Anti-ligature curtain rails (including shower curtains): risks from incorrect installation or modification

Problem

Anti-ligature curtain rail systems (including shower curtains) which are installed incorrectly, or modified, may have increased risk of being used as a point of ligature.

Action

When installing anti-ligature curtain rail systems (all makes) it is vital that manufacturers' instructions are followed.

Action by

Managers, staff and contractors involved in the specification, installation, maintenance or risk assessment of curtain rail systems, as well as those involved in patient care.

Contact

Specific manufacturers and suppliers of anti-ligature curtain rail systems.

Problem

Two separate incidents have been reported involving suicide in a mental health ward. In both incidents, the patient improvised a point of ligature using parts of an anti-ligature curtain rail system. This was made easier as the systems had not been installed according to the manufacturer's instructions. Neither of the anti-ligature curtain rail systems mentioned below are considered to be defective when installed correctly

Background

1. **Incident 1** involved a Silent Gliss 6650 system.

   a) The manufacturer's installation instructions differ for straight rail installations (wall to wall) and curved rail installations (those which contain corner sections). In this case, the system was a straight rail type but the wall bracket was installed and configured for use with a curved rail (see point d below). Other Silent Gliss curtain rails in the hospital were also found to be installed incorrectly by a third party.

   b) The specified parts are vital in determining how the system operates when a weight is applied to the curtain rail. In particular, the manufacturer's instructions state that "close attention must be paid to the use of the correct number of screws".

   c) One screw should be used per bracket for curved rails, located centrally to allow the bracket to rotate during collapse. An additional clear acrylic disc should be used on uneven or textured wall surfaces to ensure rotation of the bracket (see Appendix, Figures 1 and 2). However, two screws are required per wall bracket for straight rail installations. The omission of the second screw in this incident may have made it easier for the patient to use the wall bracket as a point of ligature.

   d) Subsequent to installation, staff removed the curtain rail (temporarily) to prevent it being used as a weapon. The wall brackets were left in place, which may have drawn the patient's attention to them.

2. **Incident 2** involved a Tidy Joint® Safe Trak system (see Appendix, Figures 3 and 4).

   a) It is likely that some components were not installed as required, as they were missing after the incident. Despite a search of the area these were never found.

   b) One of the missing components, the anti-deflection block, was designed to correctly position the curtain rail and reduce the risk of it being used as a point of ligature. The manufacturer's installation instructions state that the anti-deflection block should be secured in place.

3. Anti-ligature curtain rail systems are not intended to be 'ligature proof' or used as a substitute for routine risk assessment and supervision.

Action

4. This notice should be brought to the attention of all appropriate managers, staff and contractors involved in the specification, installation, maintenance or risk assessment of curtain rail systems (including shower curtains), and those involved in patient care.

5. When installing anti-ligature curtain rail systems (all makes) it is vital that manufacturers' instructions are followed. Where possible, installation should be carried out only by persons trained by the manufacturer or approved distributor.

6. If modifying an anti-ligature curtain rail system (e.g. to reduce non-ligature risks) care should be taken to ensure that (new) ligature risks are not introduced and that the anti-ligature properties of the system are not compromised. If in doubt, contact the manufacturer / supplier for advice.

7. Best practice requires healthcare organisations to conduct regular risk assessment of the environment for patients who are at risk of suicide / self-harm and to update the assessment criteria in the light of any new information. High risk environments would include mental health wards, psychiatric intensive care and Accident and Emergency.

8. Regular inspections and tests of the anti-ligature system should be carried out as per the specific manufacturer's instructions.

9. Risk assessments will encompass non-estates factors which may necessitate close liaison with clinical and other staff. The assessment might also consider the age of any anti-ligature curtain rail systems currently in use and whether there are now better designs available which could help reduce the risk of suicide.

Suggested Onward Distribution

- Accident & Emergency
- Accommoda tion Officers
- Capital Planning & Design
- Community Care
- Estates/Faci lities
- Health & Safety
- Psychiatry
- Risk Management
- Safety Representatives
- Social Services

Additional Information for Northern Ireland

The above sections of this Alert were compiled by **Health Facilities Scotland** and distributed nationally without modification.

Action required by this alert should be **underway by: 26th April 2010**
Action required by this alert should be **completed by: 30th August 2010**

Enquires should quote reference number EFA/2010/003 and be addressed to:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast
BT16 1US
Tel: 02890 523868
Fax: 02890 523900
E-mail: NIAIC@dhsspsni.gov.uk
Website: http://www.dhsspsni.gov.uk/niaic

How to report adverse incidents

Incidents relating to medical devices, estates equipment and plant in Northern Ireland must be reported to the Northern Ireland Adverse Incident Centre (NIAIC) as soon as possible. Further information about reporting incidents can be found in DB(NI)2010-001; and downloadable report forms are available from the NIAIC's website (http://www.dhsspsni.gov.uk/niaic).

Alternatively, further information and printed incident report forms are available from: NIAIC at the address above.
(An answer phone service operates outside normal office hours)

Estates and Facilities Alerts are available in full text on the NIAC website
Further information about SABS can be found at http://sabs.dhsspsni.gov.uk
This Alert can be found on the following websites
http://www.dhsspsni.gov.uk/niaic and http://sabs.dhsspsni.gov.uk

APPENDIX

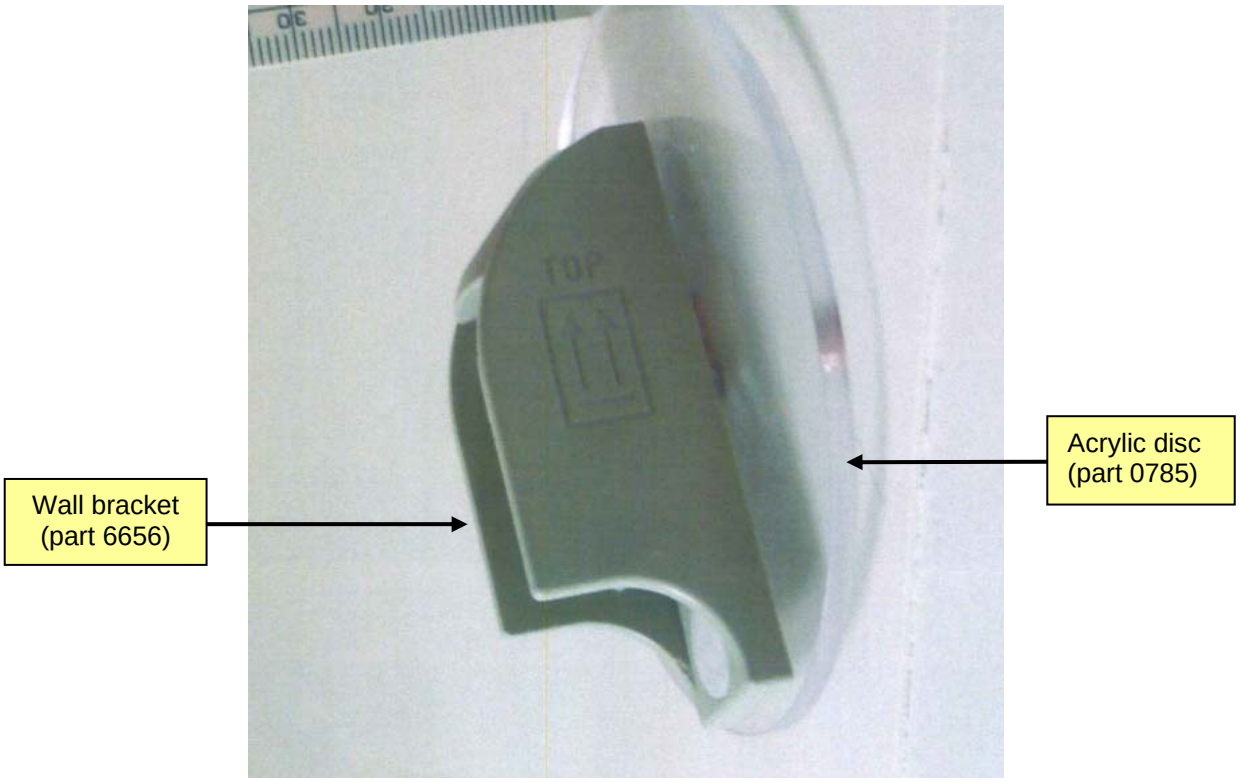

Figure 1
Silent Gliss anti-ligature wall bracket mounted on wall with single screw – set up for a curved rail installation
(disc normally only required for use on uneven or textured wall surfaces)

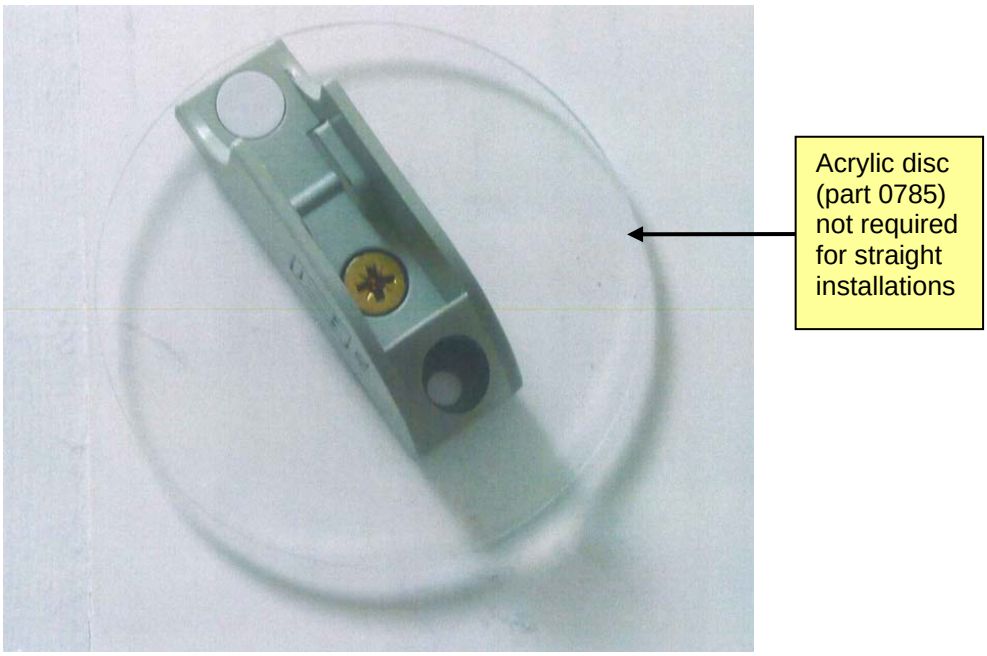

Figure 2
Silent Gliss anti-ligature wall bracket mounted on wall with single screw – incorrect set up for a straight rail installation (and rotated upside down).

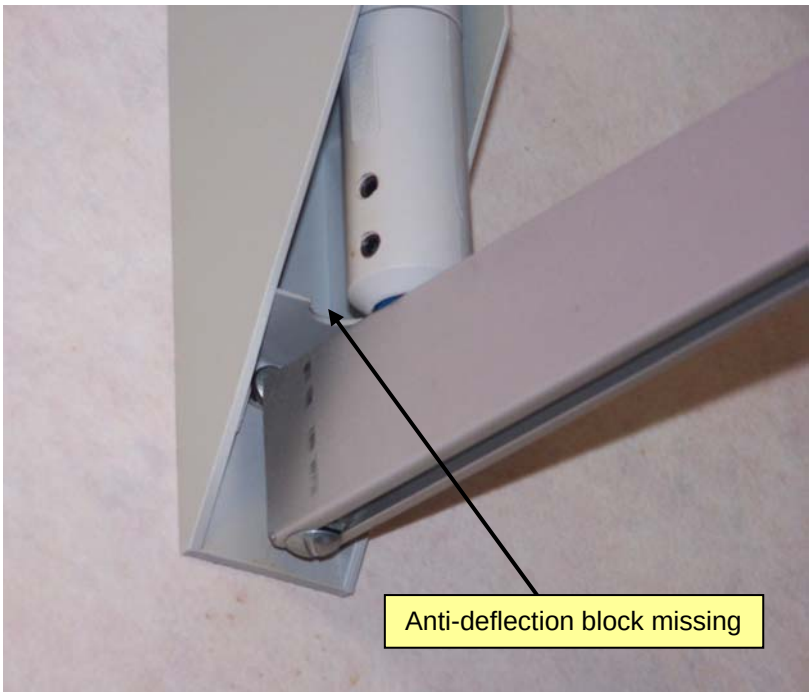

Figure 3
Tidy Joint® Safe Trak - incorrect installation

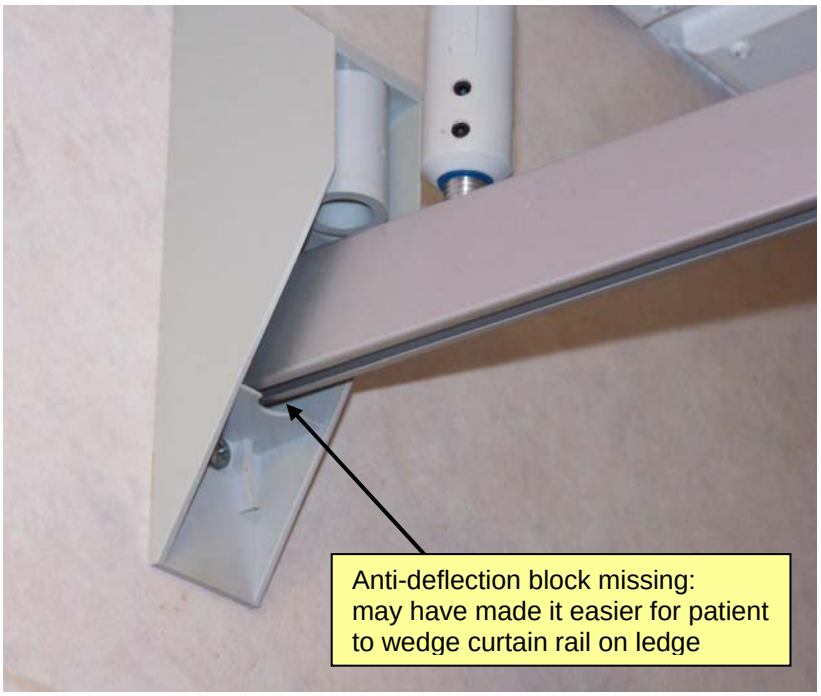

Figure 4
Tidy Joint® Safe Trak – modified by patient to prevent rail dropping